DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MEDICAL ASSISTANCE ADMINISTRATION
Olympia, Washington

To: ITA Providers
Managed Care Plans

Memorandum No: 03-82 MAA
Issued: September 29, 2003

From: Douglas Porter, Assistant Secretary
Medical Assistance Administration

For Information Contact:
Toll Free: 1-800-562-6188

Subject: Involuntary Treatment Act (ITA) Transportation: HIPAA Implementation

Effective for dates of service on and after October 1, 2003, MAA will discontinue the use of all state-unique procedure codes used in the ITA Transportation program. Replacement codes are listed in this memorandum.

Coding Changes

The Health Insurance Portability and Accountability Act (HIPAA) requires all healthcare payers to process and pay electronic claims using a standardized set of procedure codes. MAA is discontinuing all state-unique procedure codes and will require the use of applicable HCPCS* procedure codes.

Attached are replacement pages 9-10 and 17-20 for MAA's Involuntary Treatment Act (ITA) Transportation Billing Instructions, dated October 2000, which reflect HIPAA implementation.

Discontinued State-Unique Codes

The following state-unique codes will be discontinued for claims with dates of service after September 30, 2003:

Discontinued State-Unique Code	Description
0801A	Rate per consumer, per mile, one-way trip
0802A	Rate per consumer, per mile, one-way return trip
0803A	Extra attendant

*HCPCS stands for Healthcare Common Procedure Coding System.

Billing for ITA Transportation Services Using HCPCS Codes

Use the following HCPCS codes to bill for ITA Transportation services:

Discontinued State-Unique Code	Replacement HCPCS Code	Brief Description
0801A	S0215	Non emergency transportation; mileage, per mile
0803A	T2001	Non emergency transportation; patient attendant/escort

To obtain this memorandum electronically, go to MAA's website at http://maa.dshs.wa.gov (Click on the Provider Publications/Fee Schedules link).

Driver Requirements

Each designated organization must include the following criteria in its driver selection process:

- Verify that the driver has a valid state driver's license;
- Verify that the driver has not had any major moving traffic violations for the past three years and has not been involved in any at-fault accidents within the past two years; and
- Verify that the driver is physically capable of safely handling consumers and capable of safely driving the vehicles. It is recommended that verification of these abilities be in the form of a written medical statement, or, if not available, some other form of credible verification.

Driver Training

Drivers must be completely familiar with their job and be able to use all accessory equipment in a safe manner. A driver-training program includes:

- First aid training including current cardio-pulmonary resuscitation (CPR) certification; and
- The operation and use of all equipment associated with the job.

Fee Schedule

Procedure Code	Description	Maximum Allowable
S0215	Non emergency transportation; mileage, per mile	$2.98/mile
T2001	Non emergency transportation; patient attendant/escort	$6.36/trip

- The mileage rate is only for those miles that the involuntarily detained consumer is on-board the vehicle (loaded mileage). MAA does not allow any additional charges beyond the rate per mile allowance.
- MAA reimburses for transportation services at a provider's usual and customary rate or MAA's maximum allowable per mile, whichever is less, for each eligible involuntarily detained consumer.
- MAA considers its payment as payment in full. MAA allows no additional charge to the involuntarily detained consumer.

☞ **Note:** Form 13-628 must be completed and attached to the HCFA-1500 claim form.

☞ **Note:** In box 19 of the HCFA-1500 claim form, indicate "ITA."

11d. **Is There Another Health Benefit Plan?:** Required if the client has secondary insurance. Indicate *yes* or *no*. If yes, you should have completed *fields 9a.-d*. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes*. **If 11d. is left blank, the claim may be processed and denied in error.**

17. **Name of Referring Physician or Other Source**: When applicable. Enter the referring physician or Primary Care Case Manager name.

17a. **I.D. Number of Referring Physician**: Enter the seven-digit, MAA-assigned identification number of the provider who *referred or ordered* the medical service; OR 2) when the Primary Care Case Manager (PCCM) referred the service, enter his/her seven-digit identification number here. If the client is enrolled in a PCCM plan and the PCCM referral number is not in this field when you bill MAA, the claim will be denied.

19. **Reserved for local use**: Required. Enter "ITA."

21. **Diagnosis or Nature of Illness or Injury**: When applicable, enter the appropriate diagnosis code(s) in areas 1, 2, 3, and 4.

22. **Medicaid Resubmission**: When applicable. If this billing is being submitted beyond the 365-day billing time limit, enter the ICN that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the Remittance and Status Report.)

23. **Prior Authorization Number for Limitation Extensions:** When applicable. If the service you are billing for requires authorization, enter the nine-digit number assigned to you. Only one authorization number is allowed per claim.

24. **Enter only one (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form**.

24A. **Date(s) of Service**: Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., October 04, 2003 = 100403). **Do not use slashes, dashes, or hyphens to separate month, day, or year (MMDDYY).**

24B. **Place of Service**: Required. Enter **99.**

24C. **Type of Service**: Not required.

24D. **Procedures, Services or Supplies CPT/HCPCS**: Required. Enter the appropriate CPT or HCFA Common Procedure Coding System (HCPCs) or state unique procedure code from the fee schedule in these billing instructions for the services being billed.

24E. **Diagnosis Code**: Required. Enter the ICD-9-CM diagnosis code or V68.9. When code V68.9 is used, written justification noting condition requiring level of service is necessary (enter in *field 21*).

24F. **$ Charges**: Required. Enter your usual and customary charge for the service performed. Do not include dollar signs or decimals in this field.

24G. **Days or Units**: Required. Enter the appropriate number of units.

25. **Federal Tax I.D. Number: Leave this field blank.**

26. **Your Patient's Account No.**: Not required. Enter an alphanumeric ID number, i.e., a medical record number or patient account number. This number will be printed on your Remittance and Status Report under the heading *Patient Account Number*.

28. **Total Charge**: Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. **Amount Paid**: If you receive an insurance payment or client-paid amount, show the amount here, and attach a copy of the insurance EOB. If payment is received from source(s) other than insurance, specify the source in *field 10d*. Do not use dollar signs or decimals in this field or put Medicare payment here.

30. **Balance Due**: Required. Enter balance due. Enter total charges minus any amount(s) in *field 29*. Do not use dollar signs or decimals in this field.

33. **Physician's, Supplier's Billing Name, Address, Zip Code and Telephone Number**: Required. Put the *Name, Address,* and *Telephone Number* on all claim forms.

PIN: Enter the seven-digit number assigned to you by MAA here.

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

SAMPLE

Must attach ITA Form 13-628

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☒ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): S-040256SMITHA

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): LEWIS PETER B

3. PATIENT'S BIRTH DATE MM DD YY: 04 02 56 SEX M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 60 BURGESS AVE #201

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

CITY: UPTOWN STATE: WA

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY: STATE:

ZIP CODE: 98000 TELEPHONE (Include Area Code): ( )

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☒

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☒ PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES ☐ NO ☒

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☒ *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. V68.9 3. ____.__

2. ____.__ 4. ____.__

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 10 15 03	10 15 03	99		S0215		V68.9	1490	5				
2 10 15 03	10 15 03	99		T2001		V68.9	636	1				
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. $ TOTAL CHARGE: 2126

29. $ AMOUNT PAID:

30. $ BALANCE DUE: 2126

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

UPTOWN SHERIFFS DEPARTMENT
22 1ST AVE
ANYWHERE, WA 98000 360-555-1111

PIN# 9000000 GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

Form 13-628

Go to DSHS Forms website to access/download this form:

http://www.dshs.wa.gov/dshsforms/forms/eforms.html